



AIR AMBULANCE SERVICE / VEHICLE LICENSURE / TRAUMA VERIFICATION APPLICATION

Service Name: _____ / _____
(Legal Name) (Also Known As)

Address: _____ EMS Agency/License #: _____
(If known)

City: _____ State: _____ Zip: _____

Owner/Operator: _____ Phone: _____

Physician Director: _____ Phone: _____

EMS Training Officer: _____ Phone: _____

E-Mail Address: _____ FAX: _____

NOTE: If your agency operates as an Air Ambulance AND Ground Ambulance, a separate application is required for each part of the operation.

TRAUMA VERIFICATION REQUESTED? Yes ☐ No ☐

DOES YOUR SERVICE UTILIZE EMS PERSONNEL? Yes ☐ No ☐

IF UTILIZING EMS PERSONNEL, PLEASE CHECK THE LEVEL OF CARE PROVIDED ON A 24-HOUR BASIS: BLS ☐ ILS ☐ ALS ☐

ORGANIZATION TYPE: (check the one that **best** applies to your organization)

Private For Profit ☐ Private Non-Profit ☐ Private Volunteer Association ☐
Hospital District ☐ EMS District ☐ Other (specify below) ☐

VEHICLES: Please provide the **number** of each type vehicle you are licensing (see page 2):
Air Ambulance (Fixed Wing) Air Ambulance (Rotary Wing)

RESPONSE INFO: Please provide the **number** for each EMS activity listed below, for your last full calendar year (if applicable, i.e. when changing the existing type of service. First time applicants need not provide this information):

Primary Responses Transports Primary/Secondary
Secondary Responses Interfacility Transports Only

PERSONNEL STATUS: Are your EMS personnel primarily: (check one) Paid ☐ Volunteer ☐

DO NOT DUPLICATE

**AIR AMBULANCE SERVICE / VEHICLE
LICENSURE / TRAUMA VERIFICATION APPLICATION
EMERGENCY MEDICAL *VEHICLES***

Please provide the following information for all air ambulance vehicles to be licensed. Vehicle location is the address in which the vehicle is **physically located**. Check the *type* of vehicle(s), fixed or rotary wing. Check to see that each licensed vehicle has a license sticker appropriately displayed. If there is no sticker, request one below.

YOUR SERVICE NAME: _____

| YEAR | MAKE AND MODEL | LICENSE PLATE OR FAA NUMBER | ACTUAL ADDRESS OF VEHICLE <i>(If Different From Page 1)</i> | AIR AMB FIXED | AIR AMB ROTARY | STICKER NEEDED (Yes or No) |
|------|----------------|-----------------------------|--|---------------|----------------|-------------------------------|
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| 3 | | | | | | |
| 4 | | | | | | |
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| 9 | | | | | | |
| 10 | | | | | | |
| 11 | | | | | | |
| 12 | | | | | | |

Attach extra sheets as necessary, including all the required information.

NOTE: When *adding, removing, or changing* the location of licensed vehicles, contact the licensing office, at the address or telephone number on Page 4.

DO NOT DUPLICATE

**AIR AMBULANCE SERVICE / VEHICLE
LICENSURE / TRAUMA VERIFICATION APPLICATION
EMERGENCY MEDICAL *PERSONNEL***

List all medical personnel in your organization who are providing emergency care, aid or transportation, and check the appropriate column(s). Include personnel who are full or part-time, paid or unpaid.

PLEASE KEEP A COPY OF THIS LIST ON FILE FOR INSPECTION BY THE DEPARTMENT OF HEALTH.

SERVICE NAME: _____

| NAME (LAST, FIRST, M.I.) | | EMT | IV TECH H | AW TECH | IV/AW TECH | ILS TECH H | LS/AV TECH | PM | OTHER (Specify) |
|----------------------------------|--|-----|-----------------|------------|---------------|------------------|---------------|----|--------------------|
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| 18 | | | | | | | | | |
| 19 | | | | | | | | | |
| 20 | | | | | | | | | |
| PLEASE TOTAL EACH COLUMN: | | | | | | | | | |

Attach additional sheets as necessary, including all the required information.

Legend:

EMT = Emergency Medical Technician

IV TECH = Intravenous Therapy

AW TECH = Airway Technician

IV/AW TECH = IV and Airway

ILS TECH = Intermediate Life Support

ILS/AW TECH = ILS & Airway

PM = Paramedic

OTHER = RN, MD, PA, Flight Nurse

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**AIR AMBULANCE SERVICE / VEHICLE
LICENSURE / TRAUMA VERIFICATION APPLICATION
GENERAL OPERATION**

Please describe the **general operation** of your service; including how it will operate in a manner consistent with WAC 246-976, the State EMS & Trauma Plan. *(Please find this information on our website at www.doh.wa.gov/hsqa/emtp click on "Licensure Processes." If you require hard copies of this information, please contact the Licensing and Certification office, shown at the bottom of this application).* Provide an explanation of your:

1. Dispatch plan

2. Response plan

3. Response area

4. Type of transport (emergency and/or interfacility), if any

5. Tiered response and rendezvous, if any

6. Back-up plan to respond

NOTE: Other services involved in your response plan must be informed by you that they are participants and must agree to that participation. Attach extra sheets as necessary.

"I/We hereby affirm and declare that the information provided is true and correct and that:

- 1. Our service operates in a manner, which is consistent with the State EMS & Trauma Plan;*
- 2. Our service, and all vehicles submitted for licensure on Page 2, meet minimum requirements provided in WAC 246-976 (Air Ambulance Services);*
- 3. Our service meets all FAA regulations;*
- 4. A copy of our current FAA certificate and operational specifications is attached to this application;*
- 5. Our Physician Director is a Washington-State licensed physician;*
- 6. We maintain current liability insurance coverage (copy attached)."*

Person Completing Application (Print or Type)

Date

Owner/Operator (Signature & Title)

Date

DO NOT DUPLICATE

OEMTP / L&C, PO BOX 47853, OLYMPIA, WASHINGTON 98504-7853 / (360) 236-2845 / 1-800-458-5281, Ext. #1